Annual Report on the Effectiveness of Safeguarding Children in Bury 2016/17

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1. Foreword

At the end of the financial year 2015/16 BSCB members said goodbye to Gill Rigg after seven years as the BSCB Independent Chair. In 2016/17 we welcomed Sharon Beattie as our new Independent Chair when she took over the role at the beginning of April 2016. Due to unforeseen circumstances Sharon has been unable to continue in the role going forward into the new financial year. At the time of writing this report efforts are underway to recruit a new BSCB Independent Chair. Working with our partners in the Adult Safeguarding Board and recognising the shared benefits of closer co-operation we will be recruiting a joint Independent Chair for both Boards. The Annual Report foreword is usually produced by the BSCB Independent Chair. LSCB members have agreed that this foreword is a collaboration on behalf of all our partners.

This BSCB Annual Report is a requirement of Working Together 2015, the statutory guidance and the report is expected to identify the effectiveness of child safeguarding and promoting the welfare of children in Bury. It is required to provide a rigorous and transparent assessment of the performance and effectiveness of local services. It is our aspiration that this report does that and it will be of relevance and useful to anyone with an interest in safeguarding in Bury. In the previous financial year the Board benefited from external scrutiny when Ofsted conducted its review of the effectiveness of the Board, and judged it to be good. However, in no way was the Board complacent, and whilst this report describes the activity of the Board in 2016-17, plans were developed to continue to improve safeguarding activity in 2017 and beyond. Over the past year, a priority for us has been to ensure that the combined impact of a change of Chair and the significant developments regarding the future of Local Safeguarding Children Boards (brought about by the Wood Review and the Government response) have not adversely affected our enthusiasm and commitment to improve.

The report details the activity of the Board, which is made up of the main Board, the Business Group, and the sub groups. It describes a significant amount of highly effective work by partner agencies, who work tirelessly to keep children and young people as safe as possible in Bury. We have been grateful for all the work which constituent agencies undertake on behalf of the Board.

The report describes an analysis of how effective safeguarding is in Bury, the auditing activity and the performance data. It describes performance against the Business Plan, and some key areas of activity, the continued implementation of findings from our audit work and learning reviews, and the ongoing development of Child Sexual Exploitation activity.

Bury Safeguarding Children Board members
September 2017

2. The role of the LSCB

Bury Safeguarding Children Board (BSCB) is a statutory body established under the Children Act 2004. It is independently chaired and consists of senior representatives of all the statutory partners working together to safeguard children and young people in Bury. Its statutory responsibilities are to:

- Co-ordinate local work to safeguard and promote the welfare of children and young people
- To ensure the effectiveness of that work

The remit of this Annual Report

This report sets out progress made by Bury LSCB in 2016/17 with its partners, and analyses the effectiveness of

- Safeguarding arrangements in Bury
- The BSCB in supporting and coordinating safeguarding arrangements and in monitoring and challenging those who provide them.

The report has been circulated to BSCB Business Group members and to BSCB members for comment and finalised during September 2017. It will be submitted to the Bury Council Chief Executive and Lead member. It will be presented to the Bury Health and Well-Being Board on 11 December 2017. It will be submitted to the Greater Manchester Mayor together with a combine Greater Manchester LSCBs Annual Report.

The BSCB structure can be found on page 8.

The annual BSCB Business Plan sets out objectives and tasks within the BSCB's strategic priorities, identifying which sub groups will lead and timescales for completion.

The BSCB engages with other strategic bodies in Bury.

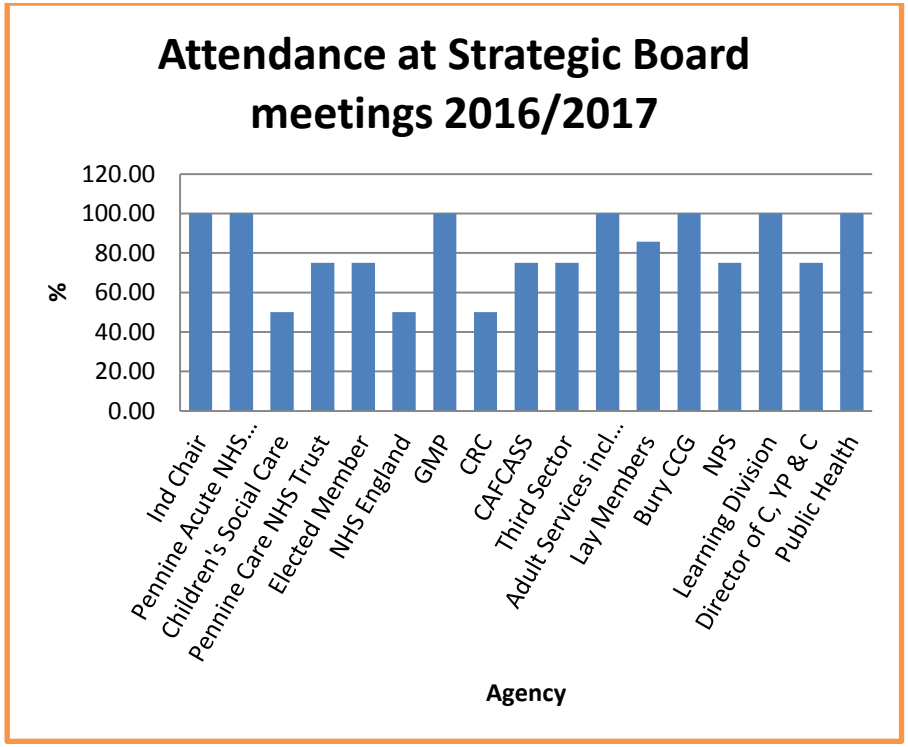
3. LSCB partners

BSCB partners continue to demonstrate their commitment to safeguarding by good attendance and by providing the resources that are needed to ensure an effective LSCB. Continuing financial restrictions on the public sector did result in reduced contributions in 2016/17 from both the Community Rehabilitation Company and the National Probation Service.

BSCB Budget

Local Authority Children's Services	£42,145.00
Bury CCG	£37,142.00
Greater Manchester Police	£11,850.00
CAFCASS	£550.00
National Probation Service	£896.40
Community Rehabilitation Company	£2,080.80
Direct Schools Grant	£40,000.00
Total	**£134,664.20**

A summary of projected income and expenditure can be found in ***appendix 1.***



4. How the BSCB undertakes its work

BSCB meets quarterly with Business Group meetings taking place six weekly in the intervening months.

The work of the BSCB is undertaken through its sub groups (see structure on page 8) and is reliant on input from staff from partner agencies supported by the BSCB Team. This year we welcomed a new Independent Chair to the BSCB Sharon Beattie.

In response to the Wood review of LSCBs the Independent Chair commissioned a Development Day facilitated by Professor Nick Frost, Independent Chair of North Yorkshire LSCB. Our partners were invited to discuss the Wood report and consider the question **"WHAT SHOULD 'POST LSCB' LOOK LIKE IN BURY?"** The Development Day provided an opportunity to review our structures and processes. The challenge we set ourselves was to better hold our partners to account for improving safeguarding practice.

Members reported that capacity issues meant that it was proving challenging to attend every sub group. After a formal review it was agreed to reduce any duplication by reducing and/or merging the number of sub groups. We agreed that the Business Group will be maintained and should continue to focus on reviewing the Business Plan. Sub groups continue to report to the Business Group.

The strategic board continues to meet four times per year and this year we have also employed a different approach holding themed discussions at meetings in line with BSCB priority areas.

It was agreed that sub group activity should continue to focus on BSCB priority areas. We have agreed to:

To retain:

- CSE & Missing Sub Group (membership unchanged)
- Safeguarding Schools & Colleges Sub Group (membership unchanged)
- Monitoring & Evaluation (proposed rename to Quality Assurance Sub Group (membership unchanged)
- Child Death Overview Panel (CDOP)

Merge:

- Learning & Development & Case Review & Learning Sub Group (membership to be reviewed)

Disestablished:

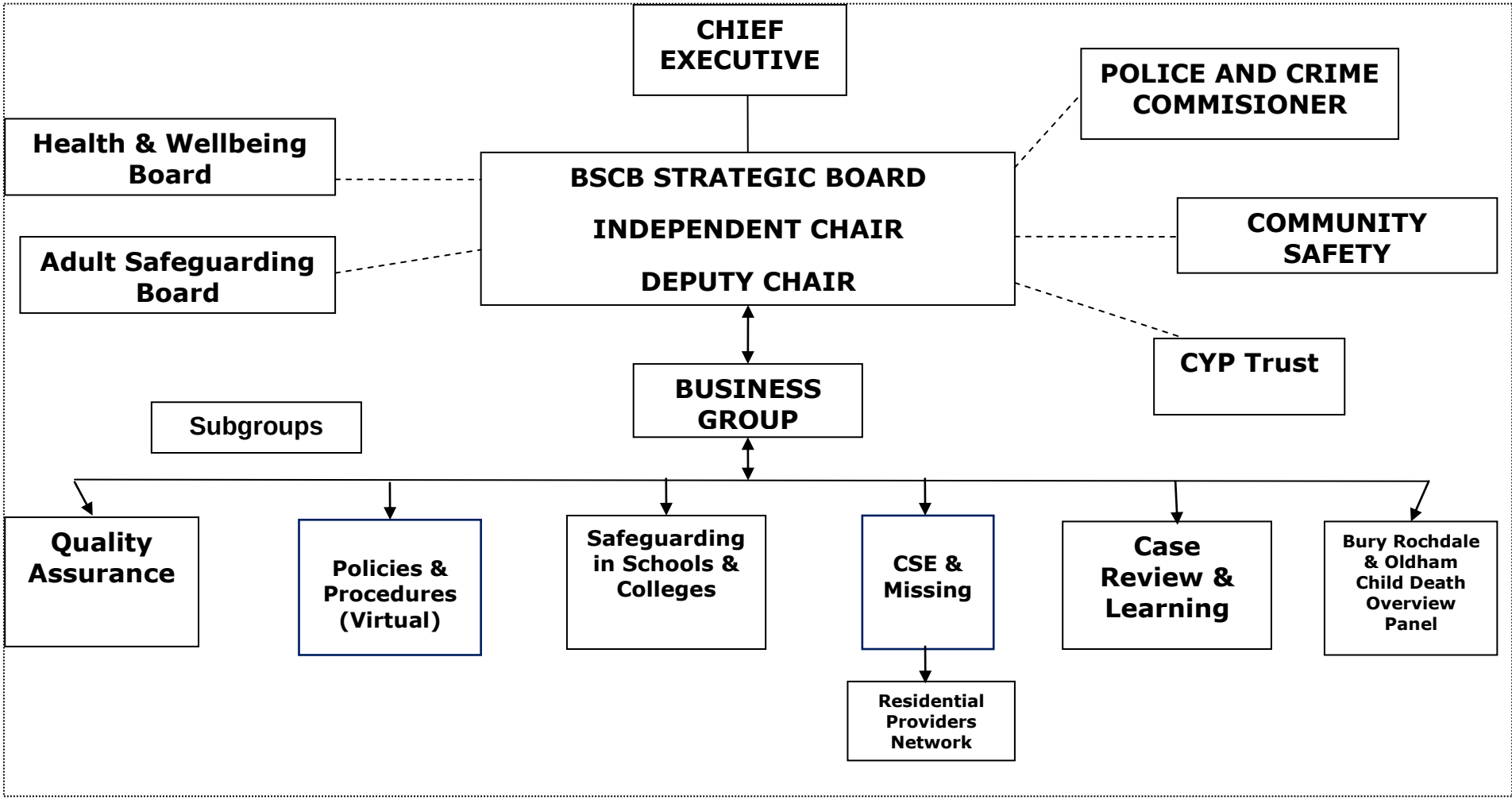
- Children Living Away from Home Sub Group. It was agreed that the BSCB should hold the Corporate Parenting Board to account for improved outcomes for Looked After Children. The Private Fostering Action Plan will be scrutinised by the Business Group. The welfare of children living in secure/long stay mental health establishments will be scrutinised under Priority 4 in the BSCB Business Plan 2017/18 'safeguarding children who have mental health needs'.

Working Groups:

- **On line safety**-this work will be led by and scrutinised via the Safeguarding Schools and Colleges Sub Group.
- **Residential Providers**-this is a networking meeting held twice per year by the LADO reporting to the CSE & Missing Sub Group.

The commitment shown by our partners to the work of the BSCB and their staff in the context of continuing austerity is testament to shared intent across the partnership to improve multi-agency working and outcomes for children and young people.

BSCB Structure Chart (as of 2017)



5. Promoting effective partnership working

Widening partnerships on a regional basis has been a priority for the BSCB over the last twelve months. BSCB collaborates on a Greater Manchester basis with other Greater Manchester Local Safeguarding Children Boards and is represented on the Greater Manchester Safeguarding Partnership (GMSP).

GM|SP

The GMSP consists of representatives from all Local Safeguarding Children Boards and key agencies across Greater Manchester and coordinates collaborative projects and promotes a consistency of approach.

Recent examples of BSCB collaboration include the development of a Greater Manchester wide neglect strategy. We continue to collaborate on a GM wide basis with our neighbouring LSCBs to produce and revise the pan Greater Manchester multi-agency Safeguarding Procedures. In 2016/17 two successful updates of the procedures were completed ensuring that procedures are up to date, comprehensive and reflect local and national priorities.

This year the BSCB also participated with neighbouring LSCBs and with our colleagues from the Adult Safeguarding Board in the Greater Manchester wide strategic approach to complex safeguarding including Human Trafficking, Modern Slavery and a coordinated strategic response to missing children. Recent practice developments include the 'Footsteps' project funded by the Police & Crime Commissioner that provides an enhanced service to a cohort of children who go missing between 2 to 5 times. We will be scrutinising the impact of this service on children from Bury over 2017/18.

Collaboration is also taking place on regional basis to improve practice responses to abusive head trauma in babies. This follows on from the learning from a number of local Serious Case Reviews. BSCB members are part of a North West sector steering group to develop a local campaign to promote and support parents to respond safely to crying babies.

6. Communicating and raising awareness

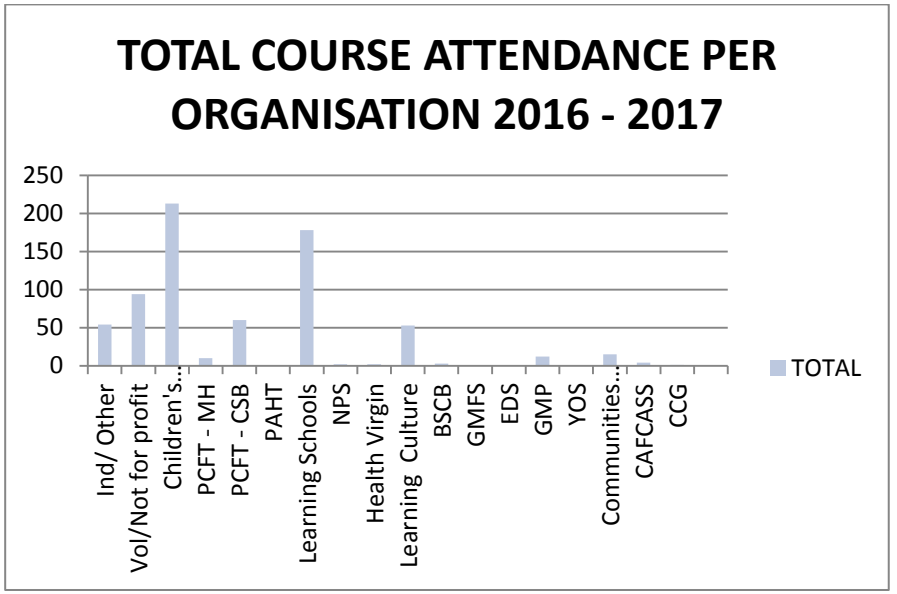
A key function of the BSCB is to ensure that key safeguarding messages and emerging lessons from its activity are disseminated quickly and effectively across the partnership.

Learning and improvement is undertaken in Bury in a number of ways, including reviews of practice, auditing, quality assurance and external learning.

The BSCB Case Review & Learning Sub Group is responsible for coordinating serious case reviews and learning reviews and for monitoring the implementation of all of the review action plans on behalf of the BSCB. The sub group is chaired by the Head of Safeguarding Bury CCG.

Leading from the BSCB Development Day in October the sub group reviewed its terms of reference and merged with the Learning and Development sub group.

All case review learning is incorporated into the BSCB multi-agency training programme. Last year the BSCB delivered a total of 34 courses to 701 participants. The sub group now has responsibility for the quality assurance of multi-agency training and for the evaluation of their impact on practice.



As part of the dissemination of learning from reviews and audit activity the BSCB also produces a quarterly e-bulletin.

The sub group also leads on the delivery of a BSCB Practitioners' Forum that is held quarterly and enables further exploration of the learning. This year we have held discussions on FGM, Fabricated Illness, Forced Marriage and Harmful Sexual Behaviour. The discussion sessions seek to raise the profile of the BSCB and its work with front line practitioners. They also provide practitioners with the opportunity to feedback any practice issues to strategic decision makers for action. Our practitioner forums have been very successful and have been attended by 115 staff.

Bury LSCB @BuryLSCB

BSCB Practitioner's Forum (Theme: Honour Based Violence) at 12 to 2 pm tomorrow (15/03/17) at DTC. Further info on http://www.safeguardingburychildren.org.uk .

In 2016/17 we embraced the use of social media to raise awareness of our work. In April 2016 we began to use twitter 

to raise awareness of BSCB activity, promote safeguarding messages and participate in local and national campaigns. Today we have over 340 followers and aim to raise this number in the next twelve months.

7. Holding partners to account

The BSCB's understanding of and scrutiny of safeguarding practice is informed by the work of the BSCB Quality Assurance sub group. The sub group is chaired by the Strategic Lead for Quality Assurance Children's Social Care. The sub group undertakes its quality assurance functions by two key processes: a programme of multi-agency audit and the monitoring and reporting to the BSCB of a multi-agency data set.

1. Auditing

The BSCB employs a range of methodologies to carry out multi-agency audits. These include audits of case records by partners, feedback from parents/carers to the BSCB Quality Assurance & Performance Officer, feedback from professionals involved, external peer review and direct observations of practice. All learning from audits is followed by an action plan/tracker that is monitored by the most appropriate BSCB sub group. Audits have considered the following practice areas:

- Child protection case conferences
- Step-down processes
- CSE Peer Review (Project Phoenix)
- Core group working

Following on from the learning from the Ofsted Review of the LSCB undertaken in 2015/6 we have required our partners to provide evidence and outcomes in terms of their own single agency audits. Areas for improvement from both our multi-agency and single agency audits have included:

- Timely distribution of CIN/CP minutes

- More focused review of child protection plans in core groups and conferences
- Voice of the child and the participation of children and young people

2. BSCB multi-agency data set

Through the recruitment of a permanent Quality Assurance & Performance Officer we have produced a comprehensive multi-agency data set and exception report for the financial year 2016/17. Concerns have been escalated throughout the year to BSCB partners for response and clarification. Concerns have also been reviewed by partners via the BSCB risk register.

Challenges have included:

- a perceived high number of rejected referrals to Healthy Young Minds. This resulted in clarification regarding sign posting and triage of referrals.

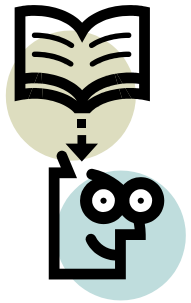
- The Marac and attendance at meetings from partners in mental health was raised as a concern. This was escalated to the Community Safety Partnership.

- Following consideration of the GM Phoenix Peer Review members were provided with reassurance from the Assistant Director Safeguarding Children's Social Care regarding the reported high caseloads in the Phoenix Team.

- The lack of data and effective mechanisms for analysing 'missing' data, & the requirement for the identification of a Local Authority Lead for Missing have been escalated to the Assistant Director Safeguarding Children's Social Care. An internal review of practice is being undertaken.

- The capacity of the police to attend multi-agency child protection conferences and reviews has been escalated to Greater Manchester Police representatives and via the Greater Manchester Independent Chairs' group.

- A delay in referrals for intervention for young people presenting to A&E with harmful alcohol misuse. High turnover of staff was identified as a factor. BSCB members were provided with assurances from the provider and information was provided regarding challenges presented by recruitment and staffing difficulties at A&E.



8. The effectiveness of safeguarding in Bury

To evaluate the effectiveness of the safeguarding arrangements in Bury evidence is drawn from a range of sources to form an evaluation of the whole system. This includes:

- Learning from both internal and external reviews and inspections
- Section 11, Section 175 & Section 157 audits
- The Child Death Overview Panel
- Performance management and quality assurance
- Young people, parents and carers
- Audit activity

External Inspections and Reviews

Ofsted Inspection of Schools

In 2016/17 92% of Bury secondary schools are judged to be good or outstanding. Of the eleven secondary schools in Bury, just one requires improvement.

The overall effectiveness profile for primary schools declined in 2016/17 and now stands at 85% good or outstanding. Targeted support is provided by the Local Authority school improvement team to those schools that have declined.

The BSCB Safeguarding in Schools and Colleges sub group has supported Bury High schools in undertaking a Section 175 self assessment. The self assessment is intended to ensure that schools have the right safeguarding governance in place. We received a positive response in 2016/17 with 64% of schools responding. The sub group will be responsible for reviewing compliance identifying any themes and actions plans going forward into 2017/18.

This year we have scrutinised the inspection reports undertaken with four of our statutory partners. We have also scrutinised the Local Authority action plan developed following the Ofsted Local Authority single inspection published in May 2016.

Care Quality Commission (CQC)

The Pennine Acute Hospitals NHS Trust (PAHT)

During February 2016 the CQC inspected services at the Pennine Acute Hospitals NHS Trust. Immediate patient safety concerns that required decisive immediate actions to stabilise services and assure patient safety were notified by the Inspectors on 1 March 2016. These were across four main service areas, Maternity, Children, Urgent Care and Critical Care.

The CQC published their full inspection report in August 2016. It rated Pennine Acute Hospitals NHS Trust overall as inadequate. The CQC overall ratings for the PAHT were:

• **Overall rating for the trust**	Inadequate
• **Are services at this trust safe?**	Inadequate
• **Are services at this trust effective?**	Requires improvement
• **Are services at this trust caring?**	Good
• **Are services at this trust responsive?**	Requires improvement
• **Are services at this trust well-led?**	Inadequate

The CQC identified 77 'must dos' and 144 'should dos' to ensure sustainable improvement. The BSCB has been provided with reassurances that action plans have been developed to address these and progress is monitored on a weekly basis.

The BSCB has received assurances from both the PAHT and the Bury CCG that the inspection findings are now subject to an improvement plan which is regularly being monitored to improve services to patients. We have been reassured that:

- A significant amount of work has been undertaken in respect of the site based leadership across Pennine Acute Hospitals NHS Trust sites.

- We have been reassured that there is combined leadership of Rochdale Infirmary and Fairfield General Hospital.

- There have been significant changes to the maternity services, which will lead to a Central Manchester service, where North Manchester General Hospital will join St Mary's Hospital in October 2017.

- Work force capability is being addressed in paediatric and maternity services. The new leadership has a new focus on staff education and are driving through measures for mandatory and job related specific training. Professional accountability is also now being monitored more robustly.

- The variation in midwifery staffing levels has stabilised to normal levels.

- Governance for the Children and Women's Division has been strengthened.

Pennine Care NHS Foundation Trust

The inspection was carried out in July 2016 across mental health services in six boroughs and community health services in six boroughs. Pennine Care NHS Foundation Trust provides mental health, community and specialist services to people living in the Bury, Heywood, Middleton, Rochdale, Oldham, Tameside, Stockport, Glossop and Trafford areas of Greater Manchester. The full inspection report was published in December 2016. The CQC overall ratings for the PCFT were:

• **Overall rating for the PCFT**	**Requires improvement**
• **Are services at this trust safe?**	**Requires improvement**
• **Are services at this trust effective ?**	**Requires improvement**
• **Are services at this trust caring ?**	**Good**
• **Are services at this trust responsive ?**	**Good**
• **Are services at this trust well-led ?**	**Requires improvement**

As the PCFT covers such a wide foot print, the BSCB has requested further information from the Trust following the inspection asking what this means for Bury children, young people and their carers.

Her Majesty's Inspection of Probation Report (HMIP)

The HMIP published their Quality & Impact Inspection report into the work of Greater Manchester (GM) National Probation Service in February 2017. The report also includes the work of the Community Rehabilitation Company (CRC). HMIP make judgements and comments using three headings and their overall ratings for the NPS are:

• **Protecting the Public**	NPS Performance was good
• **Reducing Re-offending**	the quality of work to reduce re-offending was generally acceptable but with room for improvement
• **Abiding by the Sentence**	Overall performance was good

For the Bury cases selected as part of the inspection from the Bury, Rochdale and Oldham cluster were considered in the inspection, no cases were found to have any issues or

cause for concern. This is a positive outcome for Bury NPS service users & staff when considered in the wider organisational context as the service has carried a high number of vacancies since the split between the NPS and CRC in 2015/16.

Cheshire & Greater Manchester Community Rehabilitation Company (CRC)

Protecting the Public

Public protection policies and procedures were assessed as robust but they were not being applied consistently, and so the impact of the work to protect actual and potential victims was limited. Inspectors found a degree of detachment between the strategy and practice on the ground, in particular joint work at the front-line. The quality of communication between responsible officers and social workers was inconsistent and communication was often slow. Relationships at a strategic level with children's social care services within Greater Manchester were good. There was a clear commitment from the CRC to playing an effective role in the Local Safeguarding Children Board.

Reducing Re-Offending

Progress in the delivery of interventions to support desistance had been made in too few of the cases in our sample. The quality of the work and its impact was not consistent. Assessments had largely been carried out well but planning for work to support desistance was weaker. A number of cases were found where there had been a noticeable disruption to the continuity of supervision due to frequent changes in responsible officers. In these cases, service users had struggled to build meaningful relationships.

Abiding by the Sentence

The CRC was generally effective in supporting service users to abide by their sentence. The frequency, quality, enforcement and the number of appointments offered was generally good and consequently, service users usually complied. The diversity needs of service users were not always integrated into the supervisory process in a meaningful way.

The senior management teams in the CRC and NPS were committed to partnership activities to support desistance work. Senior managers from both organisations chaired a number of groups in order to drive change that would achieve better outcomes for service users. Communication on both sides was not always effective and the two agencies were working hard to improve information exchange especially in courts. Women's services were a clear strength. The CRC was resourcing women's services effectively across Greater Manchester with the assistance of the Police and Crime Commissioner. Female service users from the CRC and the NPS were benefiting greatly from these services. The co-location of CRC and NPS staff in Integrated Offender Management teams was a significant strength. Staff were working collectively and learning from one another.

HMIP Recommendations

The Community Rehabilitation Company should:

- Fully Implement then evaluate the impact of its operating model

- Provide all staff, especially those new to the company, with regular supervision and training in effective offender management, in order to increase the focus on the quality of work

- Improve the effectiveness of the management of Unpaid Work

Action Plan

The BSCB has been reassured that there is a comprehensive CRC Action Plan in place that aims to address the themes and recommendations of the inspection. This is reviewed regularly by the CRC Senior Management Team.

Learning from Serious Incidents involving and Serious Case Reviews.

This year the Case Review and Learning sub group has considered the circumstances of 7 children. Two of those cases have been screened by an extraordinary panel to determine if the criteria was met for a Serious Case Review. In both cases it was deemed that the criteria were not met. These recommendations were supported by the BSCB Independent Chair and the National Panel.

In the first case although the panel felt that the SCR criteria were not met panel members were of the view that that there was wider learning to be gained from the case. A request was made to lead reviewer of the parallel Domestic Homicide Review (DHR) to widen the terms of reference to include children's safeguarding. Panel members framed additional questions to be considered as part of the DHR process. The request was accepted and the report has now been published.

Key lessons identified included:

- how agencies can work together to know when a reconciliation between a victim and perpetrator has, or is thought to have taken place.

- review whether agencies training on assessing risk in domestic abuse cases needs enhancing to ensure all risk factors are identified before setting the final risk level.

- seek reassurances regarding the timely process of domestic abuse notifications.

BSCB members have worked with colleagues in the Community Safety Partnership to ensure that multi-agency Domestic Abuse training is updated to incorporate the learning.

The second case concerned professional responses to a vulnerable pregnant woman whose life was chaotic and who was unwilling or unable to engage with professionals. The case was not considered to meet the criteria for a Serious Case Review and again this was supported by the National Panel. However the issues and dilemmas faced by the professionals in this case were also found in further

cases referred to the sub group indicting that these are recurring challenges and dilemmas being encountered by a range of professionals in Bury.

The sub group recommended that the case warranted further scrutiny and a joint learning review has been commissioned with the Adult Safeguarding Board. This will be undertaken by the Social Care Institute for Excellence (SCIE). The findings are due to be published in 2017/18 and will be reported in the BSCB Annual Report of the year.

9. Reviewing Child Deaths

The Bury, Oldham and Rochdale Child Death Overview Panel (CDOP) has been undertaking its role to review the death of every child aged under 18 who is resident in the area, since April 2008, with data analysed cumulatively since reviewing began.

The CDOP works to a national methodology which enables it to clarify the cause and circumstances of a child death, identify whether there were modifiable factors which contributed to the death and what, if any, actions could be taken to prevent future deaths.

An Annual Report is published every year and presented to the LSCB. The overall number of child deaths in Bury has remained largely unchanged over the last 4 years: 17 deaths in 2012/13; as compared with 17 deaths in 2015-16. However, the number of deaths fell in 2013/2014 to its lowest level (14 deaths), but has subsequently risen again over the past 3 years.

The numbers are small, and fluctuate year on year. Child death rates for Bury, both infant mortality (under 1s) and older children (1-17 years), are very similar to national rates, but lower than regional rates. However, the UK continues to have child death rates which are higher than much of Europe.

Between 2012 and 2016, 6 Bury Infants have died suddenly and unexpectedly in their sleep, without an established underlying medical cause. This represents 11.5% of all Infant deaths. Most of these infants (4) had one or more modifiable risk factors present. The prominent risk factors were household smoking (3), co-sleeping (3), loose bedding (1) sleeping on a sofa (1) and overheating (3). It is not possible to ascertain any trend in this type of death because the numbers are small, but national data suggests that Bury has an average number of such deaths compared to other areas.

10. Managing allegations against professionals

Allegations management is undertaken in Bury by a part-time Local Authority Designated Officer (LADO) employed by Children's Social Care. Processes in Bury are embedded with a high level of awareness of the role by professionals across the partnership demonstrated by increasing enquiries.

This year we saw a 45% increase in LADO related enquiries from 224 in 2015/16 to 325 in 2016/17. Of this total, 45 reached the LADO threshold, an increase of 14% from 2015/2016 (see Table 1).

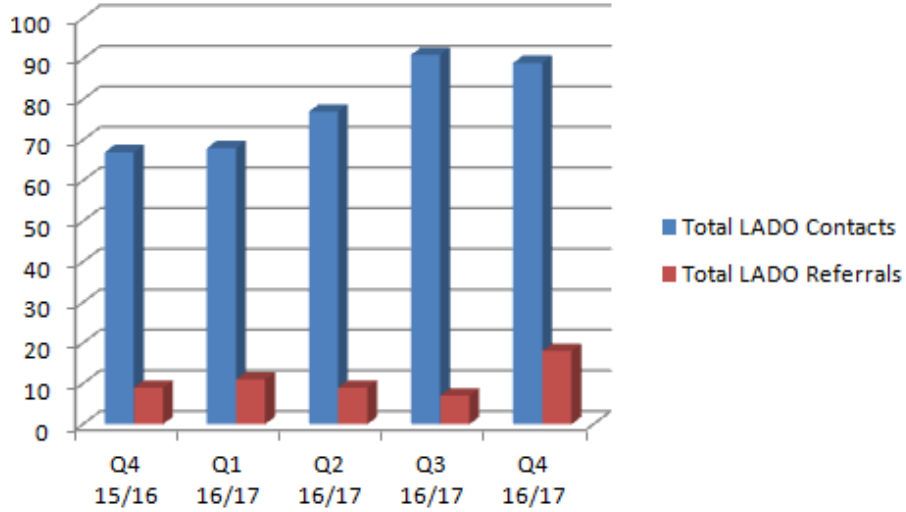


Table 1: Total number of LADO Contacts against the total numbers which reached LADO threshold.

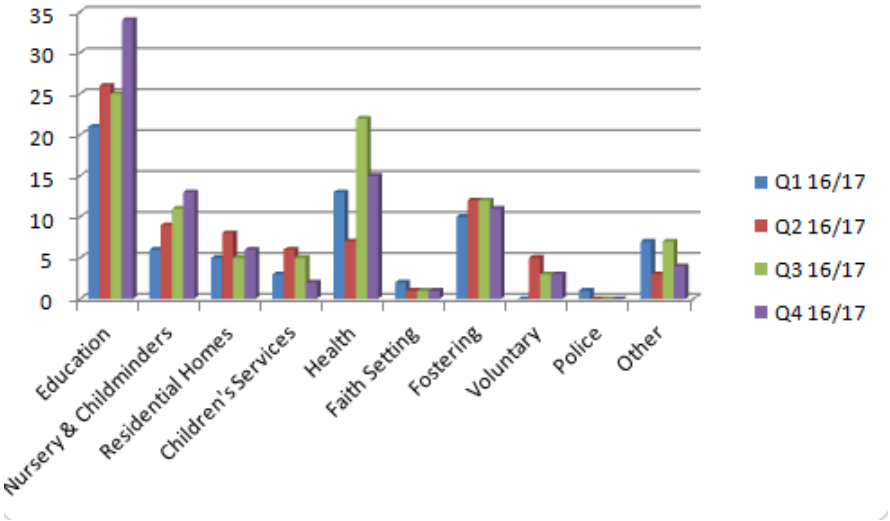


Table 2: Total number of LADO Contacts made for each sector.

The highest number of LADO Contacts made during 2016/17 related to Education settings (see Table 2). A total of 106 contacts were made, an increase of 63%, and 21 reached LADO threshold, an increase of 43%. Of those 21, 16 were categorised as 'physical' and went on for further investigation (see Table 3).

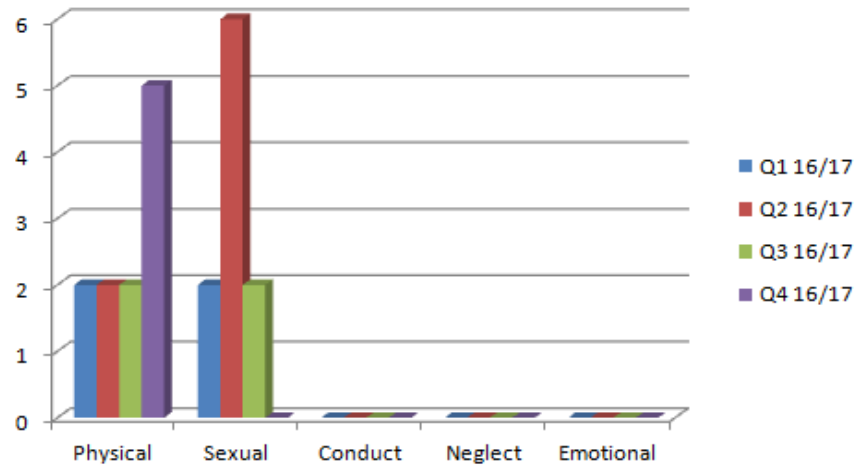


Table 3: Categories of LADO Referrals for Education settings

Training/Development activity

- Due to an increase in allegations of inappropriate physical handling of pupils by school staff, the Bury LADO is working to develop a learning/development session for School Heads and safeguarding leads in all Bury Schools about the use of "Reasonable Force" as set out in DfE Guidance.

- Concerns continue to be raised with the LADO regarding school staff inappropriately engaging with pupils/students on social media/personal mobile phones and their behaviour on-line at home. In response the LADO has delivered awareness sessions to all but 3 Bury High Schools educating them about the dangers of such engagement. The LADO also specifically discusses such inappropriate interactions in all multi-agency training delivered (Managing Allegations/Safer Recruitment and E-safety training).

- Safer Recruitment training is delivered by the BSCB three times per year (72 participants in 2016/17). Safer Recruitment processes have been developed to deter a potential offender's entry into a setting where that have easy access to children and young people.

- Partners are encouraged to 'Think the unthinkable' and implement a rigorous set of safer recruitment and reviewing procedures and maintain a culture of vigilance.

- Due to a rise in LADO contacts from the 3 Secure Mental Health Hospitals in Bury, the LADO has engaged with management of all 3 and has now delivered specific targeted LADO/managing allegations awareness sessions to management and/or staff of all 3 units.

11. Partner compliance with statutory safeguarding requirements

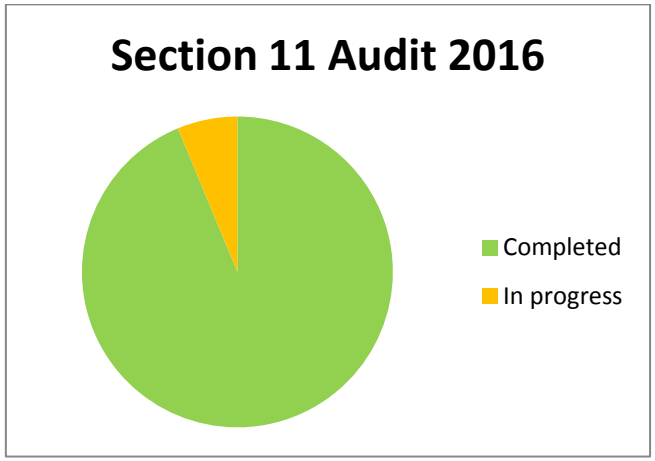
Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Section 11 forms the basis if regular self-auditing of compliance.

BSCB partners undertake a section 11 audit every two years. The audit is a multi-agency process consisting of two steps, a self assessment process and challenge sessions.

1. Self-assessment process – each organisation has completed an on-line assessment tool under three headings:

a. A culture of safeguarding children in the organisation
b. A safe organisation
c. Voice of the child, staff and community

These three headings are further broken down into 11 sections. Each organisation has provided an explanation of the services or arrangements in place under the 11 sections and evidence to prove they fulfil each requirement. A self-assessed grading was given for each section of red (not met), amber (partially met), green (fully met) or grey (not applicable).Agencies used the sections that were not met or partially met to create an action plan using the on-line tool to demonstrate how they intended to achieve these criteria.



2. Challenge Sessions

This is the first Challenge Day organised by the BSCB and was a recommendation from the 2016 OfSTED LA Inspection. The role of each agency during the Challenge Day was to present both highlights of their successes and areas requiring improvement, whilst referring to their action plan. The completed audit and action plan was viewed during the session via the Virtual College website. Presentations were followed by questions from the panel.

The aim of the challenge session was to ensure that each action plan accurately reflects the agency. Following the sessions, each agency was sent a challenge log which provided details of recommended actions and changes to audits. Analysis for the period 2016/17 suggests that overall the outcome of the Section 11 Audit has been very positive with a large majority of organisations receiving predominantly green ratings for each question. There were relatively low number of ambers and no organisations self-assessed themselves with a red rating.

Section 175/157 of the Education Act outlines the safeguarding governance that must be in place within all schools. The BSCB undertakes a section 175/157 audit every two years. The BSCB will commence its Section 175/157 process in 2017/18 with analysis and comment of these being provided within the 2017/18 BSCB Annual Report.

12. Evaluating the child's journey through the safeguarding system

The development of an integrated Bury Early Help offer began in 2014 and has been driven by the Children's Trust through the Children and Young People's Plan. The 2015-18 plan sets out the 'Children's Trust Ambitions' for children and young people, the Priorities which partners will work together to address over the next 3 years and the Children's Trust working arrangements. The Ambitions and Priorities have been developed based upon local and national data and the expertise and knowledge of the workforce and of children, young people and families.

Early Help activity cannot be easily captured as much is undertaken within single agency settings. The emphasis in Bury has however been in ensuring that '**Children and young people will have access to early help: right help, right time, right person'** Priority 1 Bury Children and Young people's Plan.

Bury's Starting Well Partnership Board provides strategic overview of progress and development of Bury's vision for 'starting well'. It focuses primarily on the Early Years agenda (antenatal to school age but also takes consideration of the wider children and young people health improvement agenda (up to age 19 years).

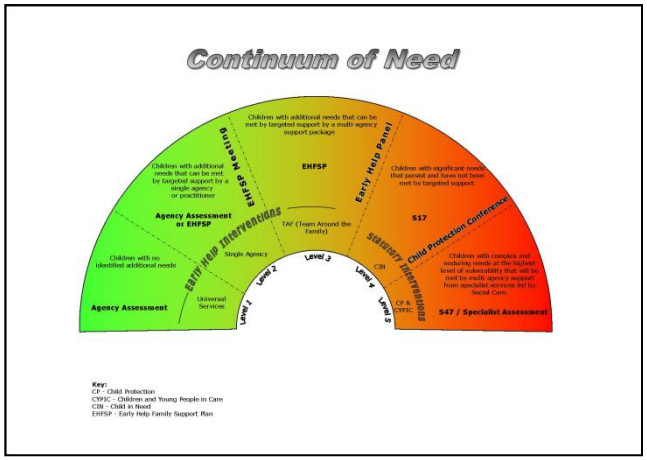
The Board has developed a Children and Young Peoples Outcomes Framework aligned with Bury's Single Outcomes Framework.

The Framework has a focus on 4 key areas:

- Improving Parental and Child Health
- Improving Education for all Children
- Promoting the economic prospects of families
- Effective early intervention in Safeguarding

A primary focus of the Early Years agenda is the implementation of the Early Years Delivery Model in Bury. A self assessment of our delivery against the model has been completed and the Greater Manchester team have undertaken an analysis of all Local Authority areas. A gap analysis has been completed and the Partnership Board are working towards the delivery of the full model as part of the Early Years Implementation Plan.

Working Together to Safeguard Children (2015) makes it clear that safeguarding children and promoting their welfare is the responsibility of all professionals working with children and that they should understand the criteria for taking action across a continuum of need. The Bury Continuum of Need guidance is intended to provide professionals with clear thresholds that should be applied consistently to ensure the right help is given to a child at the right time.



Team Oasis was established in October 2013 and is a part of the Children's Social Care early help offer in Bury. The main principle of Team Oasis is to prevent children, young people and their families from needing more specialist intervention and to support and empower families in accessing universal provision.

This approach ensures that there is a co-ordinated, multi-agency "Team around the Family" (TAF) plan in place with Specific, Measurable, Attainable, Realistic and Timely goals.

Early Help Family Support Plans

Wider early help provision in Bury is identified via an assessment of need that is called the Early Help Family support plan. Prior to April 2016, the early help assessment was called the CAF. However, due to feedback from partners and service users, this was changed in name to the Early Help Family Support Plan. The principle of the CAF process remains the same but the forms have been changed to meet the needs of Bury families with more focus around working in partnership with the family and the voice of the child.

Early Help Family Support Plans; Performance and Activity

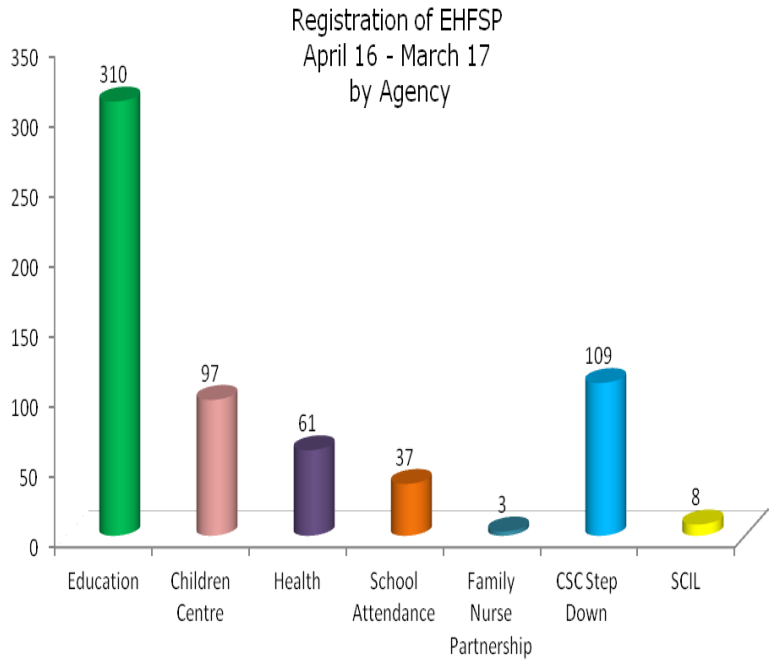
Between 1 April 2015 and 31 March 2016 there were 1044 new CAF/EHFSP's registered, this was a total 12% reduction to the previous 12 months (14/15). However, between 1 April 2016 and March 2017 we are seeing a very different picture with only 645 Early Help Family Support episodes being commenced/registered which is a 40% reduction from 2015/2016. The figures show that in Quarters 1, 2&3 (2016) there is a significant decrease in EHFSP's between 43%-49% to the same period the previous year. Although this reduction has reduced to 23% in Quarter 4 2016 which could mark a change in trajectory and further analysis of EHFSPs in quarter 1 2017 will assist to understand this further.

2014 -2015 CAF/EHFSP Total 1184			
Q1 **Apr-Jun 14**	**Q2** **Jul-Sep 14**	**Q3** **Oct-Dec 14**	**Q4** **Jan-Mar 15**
174	**290**	**344**	**376**

2015 -2016 CAF/EHFSP Total 1044			
Q1 **Apr-Jun 15**	**Q2** **Jul-Sep 15**	**Q3** **Oct-Dec 15**	**Q4** **Jan-Mar 16**
233 **(34% increase on Q1 2014)**	**270** **(7% decrease on Q2 2014)**	**278** **(19% decrease on Q3 2014)**	**263** **(30% decrease on Q4 2015)**

1.04.16 - 24.01.17 EHFSP Total 625			
Q1 **Apr-Jun 16**	**Q2** **Jul-Sep 16**	**Q3** **Oct-Dec 16**	**Q4** **Jan-Mar 16**
127 **(45% decrease on Q1 2015)**	**138** **(49% decrease on Q2 2015)**	**158** **(43% decrease on Q3 2015)**	**202** **(23% decrease on Q4 2016)**

Agencies completing Early Help Family Support Plans:



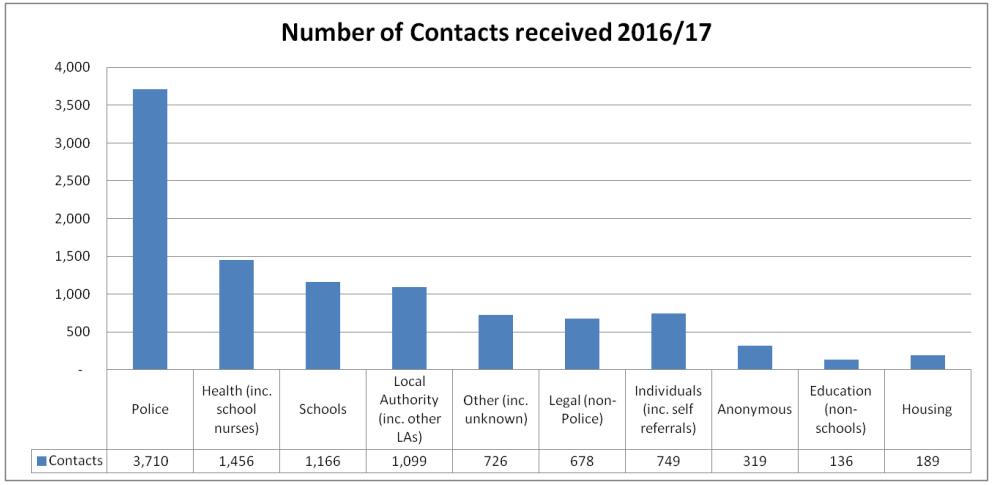
Education remain the largest contributor of EHFSPs with the next highest being step down from Childrens Social Care following an assessment that didn't require further statutory social care intervention.

A comprehensive Early Help reporting detailing early help domestic abuse initiatives such the Strive Team can be found as appendix 2 to this report.

Multi Agency Safeguarding Hub

The Multi Agency Safeguarding Hub (MASH) receives contact and referrals from partner agencies and progresses these according to the BSCB threshold criteria. A total of 10,228 contacts were received during 2016/17.

A breakdown contacts per agency is shown in the graph below:



Where it is deemed that the 'threshold' criteria are met, a 'contact' is progressed to a 'referral' to Children's Social Care. Of the 10,288 contacts received last year, 2,253 were converted into a referral. This equates to a conversion rate of 21.8%.

It is of note that when compared with the previous year the number of contacts has increased significantly; the number of referrals has seen an increased too albeit proportionally smaller.

	2015/16	**2016/17**
Number of Contacts	8,539	10,288
Number of Referrals	2,078	2,253
Conversion Rate	24.3%	21.8%

Broken down per agency the following percentage increase can be observed when comparing contacts to the MASH made during the previous year. All partner agencies increased their contacts to the MASH with the notable exception of Non-school Education:

Agency	**Increase versus 2015/16**
Individuals (inc. self referrals)	58.35%
Health (inc. school nurses)	43.59%
Schools	39.14%
Local Authority (inc. other LAs)	36.18%
Other (inc. unknown)	34.20%
Legal (non-Police)	33.20%
Housing	6.78%
Anonymous	1.59%
Police	0.76%
Education (non-schools)	-26.09%

Assessments

Of all referrals to Children's Social Care, 88.1% result in a Child and Family (C&F) assessment being completed. The suggested timescales for completion for such assessments is 45 working days.

2016-17	Apr	May	Jun	Jul	Aug	Sep
Within 45 Days	176	127	141	176	152	106
Over 45 days	40	72	81	99	84	66
% Within 45 Days	81.50%	63.80%	63.50%	63.50%	64.40%	61.60%

2016-17	Oct	Nov	Dec	Jan	Feb	Mar
Within 45 Days	181	152	163	142	179	185
Over 45 Days	81	52	77	60	40	36
% Within 45 Days	69.10%	74.50%	67.90%	70.30%	81.70%	83.70%

For a period the timeliness of C&F Assessments significantly declined during 2016/17. For the preceding year (15/16) the average assessments completed within 45 working days was 83.3%. A focussed piece of work was undertaken to bring increase the timeliness of C&F assessments whilst at the same time ensuring that the quality of the assessments was maintained.

Increase in the timeliness of C&F Assessments has continued into 2017/18.

Child Protection

In September 2016, the functions of Independent Reviewing Officer (IRO) and Child Protection Chair (CP Chair) were separated to enable each role to create a more consistent practice environment. In relation to Child Protection this resulted in an initial decline of children subject to multi agency Child Protection Plans due to a focus to prevent potential drift within the system.

2016-17	Apr	May	Jun	Jul	Aug	Sep
Child Protection	237	235	238	231	248	222
Rate per 10,000	55.6	55.1	55.8	54.2	58.1	52.0

2016-17	Oct	Nov	Dec	Jan	Feb	Mar
Child Protection	223	197	187	170	178	166
Rate per 10,000	52.3	46.2	43.8	39.9	41.7	38.9

The number of children subject to Child Protection Plans per 10,000 (the rate) has declined during the year from 55.6 per 10,000 children to 38.9. This compares with an England rate of 43.1 or a North West rate of 55.2. It had initially been envisaged that a further upwards correction would be due and this can indeed be seen when looking at the 2017/18 data this slight upwards trend can be seen.

In relation to multi agency attendance at Initial Child Protection Conferences (ICPCs) there have been some challenges in the collection and collation of this data. It is therefore noteworthy that the data below can only be seen as approximate. However, it was felt beneficial to include this as a broad indicator nevertheless.

Agency	ICPCs Invited to	ICPCs Attended	% in attendance
Case holding SW	136	136	100.0%
Parents	136	127	93.4%
Health Profs	161	148	91.9%
Children's Centres	16	13	81.3%
Education	136	100	73.5%
One Recovery	16	11	68.8%
Other	147	101	68.7%
Midwifery	38	26	68.4%
Probation	25	15	60.0%
Police	136	78	57.4%
CAMHS	10	3	30.0%
Mental Health	28	7	25.0%

Looked After Children

The Looked After Children (LAC) population has remained fairly stable for much of 2016/17 with exception of the last quarter during which a substantial increase in the LAC cohort can be observed; in the last 3 months of 2016/17 the LAC numbers increased by 40 children.

	Apr	May	Jun	Jul	Aug	Sep
Looked After Children	311	321	317	315	325	317
Rate per 10,000	72.9	75.3	74.3	73.9	76.2	74.3

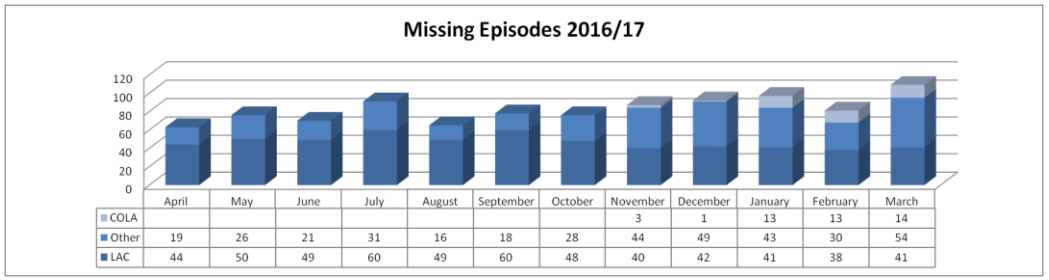
	Oct	Nov	Dec	Jan	Feb	Mar
Looked After Children	318	312	314	326	342	354
Rate per 10,000	74.6	73.1	73.6	76.4	80.2	83.0

In percentage points Bury's LAC population has increased by 19.4% since 2014/15; for the Greater Manchester Region during the same period the increase was 0.5% and for the North West 5.9%. In 2014/15, per 10,000 children living in Bury, 66 were Looked After Children, by 2016/17 this had increased to 83. For Stockport, a statistical neighbour, the rate per 10,000 children for 2016/17 was 53. An investigative piece of work is currently being undertaken to determine the story behind the sharp increase in Looked After Children.

It is of note that Bury, as the rest of the North West has proportionately higher numbers of Looked After Children who are subject to Placement with Parents regulations (i.e. looked after children who remain in the day-to-day care of their parent(s)). 41.2% of LAC placed with parents in 2016 nationally were in the North West, more than double the region's proportion of all LAC (17.8%). Discussions are taking place at a regional level to better understand this trend.

Missing Children and Child Sexual Exploitation (CSE)

Throughout 2016/17 a total of 985 missing episodes were recorded which related to 252 young people. One hundred and sixteen young people had more than one missing episode within the year. The graph below indicates the missing episodes broken down for those young people Looked After by Bury; 'Other' young people who may be subject to a CP or CIN Plan and those not known to Social Care and 'COLA': young people Looked after by another Local Authority but whose placement is within Bury.



	April	May	June	July	August	September	October	November	December	January	February	March
COLA								3	1	13	13	14
Other	19	26	21	31	16	18	28	44	49	43	30	54
LAC	44	50	49	60	49	60	48	40	42	41	38	41

It is noteworthy that throughout 2016/17 it has come to light that the data capture in relation to children who go missing was not always accurate. Improvements in recording processes have been implemented and the policy in relation to Missing is currently being reviewed to seek further efficiencies within the system.

The weaknesses in relation to data is also likely to have impacted on the reporting of Return Home Interviews. For the year 359 Return Home Interviews were recorded as having been carried out. A further 281 Return Home Interviews have been recorded as being offered but refused by the young person. Statutory Guidance seeks a Return Home Interview to be completed within 72 hours of the young person having returned to home/to the placement. In 2016/17, 157 of Return Home Interviews were completed within 72 hours (44% of all Return Home Interviews). The average time for a Return Home Interview being completed was 5.8 days.

The number of young people open to the CSE Team has remained largely static throughout the year as the table below indicates.

Young people at risk of Child Sexual Exploitation (CSE)					
Apr	May	Jun	Jul	Aug	Sep
43	47	45	44	40	48

Young people at risk of Child Sexual Exploitation (CSE)					
Oct	Nov	Dec	Jan	Feb	Mar
46	40	44	40	38	33

A comprehensive report from the Bury Phoenix Team can be found as an appendix 3 to this report.

13. The effectiveness of Bury Safeguarding Children Board

In the preceding financial year the BCSB benefited from external scrutiny. In the autumn of 2015, the BSCB commissioned a Peer Review of its work, and in May 2016, Ofsted published its review of the effectiveness of the BSCB, and judged it to be good. The details of their findings were contained within in the state of safeguarding section of last year's report. However, in no way was the BCSB complacent with plans developed to continue to improve safeguarding activity in 2016/17 and beyond. The BSCB has monitored its progress against its objectives, self-challenges and responsibilities through a variety methods:

- The Business Plan which indicates that the majority of tasks were completed or proceeding on time

- The Quality Assurance Framework, which indicates continuing partner compliance with safeguarding requirements and assurance that the quality of multi-agency interventions with children and young people is steadily improving

- The review of work to address self-challenges, which indicates that progress had been made all the challenges set for 2016/17

What Impact is the Board having?
The BSCB Learning and Improvement Framework brings together a structure of continuous learning which improves practitioner responses to children and young people at risk. This is undertaken thorough:

Findings and lessons from the broad range of work undertaken by the LSCB and partners are effectively disseminated across the partnership using a range of methods such as:

- Training and development programmes of work for staff across Bury

- Learning from Learning Reviews SCRs and audit activity shared across the partnership.

- Bulletins and website

Monitoring actions that are being undertaken to improve services such as:

- Section 11, 175/157
- External Inspections
- Risk register
- Challenge log
- The monitoring of action plans
- The impact on practice, multi-agency working and outcomes for children and young people.

Multi-agency policies and procedures that continue to underpin practice and multi-agency working. This significantly helps to consolidate and improve the functioning of the children's safeguarding system in order to better support vulnerable children and young people.

14. Progress against challenges the BSCB set itself in 2016/17

In our annual report 2015/16 we set ourselves a number of challenges to support and improve multi-agency working. These challenges were informed by the Ofsted Single Inspection and review of the BSCB published in May 2016. We reported that the BSCB needs to improve:-

1. Its oversight and challenge in respect of the outcomes for all looked after children.
2. The identification and assessment of children living in private fostering arrangements.
3. Its scrutiny and challenge of multi-agency performance data.
4. Actively listening to the voices of children and young people, particularly children from diverse backgrounds.

How we did?

1. The published Ofsted report identified that 'Services for children and young people who are looked after require further work to ensure good outcomes for all children and young people' Ofsted May 2016. In response we revised and improved our scrutiny of the services provided to Looked After Children in a number of ways. We have scrutinised and received six monthly progress reports of the Local Authority Ofsted action plan, we have sought reassurances regarding the services provided to Looked After Children who go missing, we have received performance reports from our health partners regarding children who are detained in local secure psychiatric hospitals. The regular reporting from the Corporate Parenting Board better enables us to monitor outcomes for Looked After Children and to hold our partners to account. Examples of challenge include the welfare of looked after children in custody, numbers of young people detained in police custody and educational outcomes for some pupils (key stage 4, attainment 8 and progress 8 scores) are below the national average for looked after children. We have received reassurances from the Local Authority through scrutiny of Ofsted action plans that progress is being made to raise educational attainment and a new appointment has been made to the post of virtual head teacher (VHT).

2. Numbers of children identified as living in Private Fostering arrangements in Bury has historically been low. This is despite ongoing campaigns to raise awareness. In 2016/17 we adopted a different approach to awareness raising using social media platforms and hosting a Private Fostering week campaign. This resulted in an increase in the number of arrangements being identified (form 1 in 2015/16 to 5 in 2016/17). The BSCB Business Group continues to scrutinise the Private Fostering action plan and receives six monthly reports of practice and

updates on action plans for improvement. We have been reassured though single agency audit that practice is improving to support children once these arrangements have been identified. A comprehensive Private Fostering Annual report can be found as appendix 4 to this report.

3. In the BSCB Annual Report 2015/16 we reported that the BSCB multi-agency data set was not sufficiently well developed and was focused too narrowly on Children's Social Care. Partner commitment to the multi-agency data set was also variable. This analysis was also supported by Ofsted.

In 2016/17 BSCB partners agreed to recruit to a dedicated BSCB Quality Assurance and Performance Officer post. A part time officer joined the BSCB in Q4 of 2015/16. In 2016/17 we successfully focused our efforts to improve the quality of multi-agency performance data so that the rigour of our scrutiny of frontline practice across all partner agencies improved.

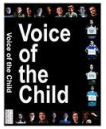
We have completed exception reports throughout the year and have been able to challenge our partners through the Business Group where it is felt that practice may fall short these issues have been escalated to the BSCB for resolution where appropriate examples are discussed in more detail in section 6.

We also strengthened the BSCB's understanding of the effectiveness of frontline services by requesting that our partners provide a clearer picture of single agency quality assurance activity sharing local lessons learned and improvement actions being taken across the system.

4. Hearing the voice of children and young people.

In October 2016 a focus group of children and young people contributed to the BSCB Development Day. The young people led a discussion regarding social media and e-safety. Their views proved very valuable and contributed to the development and actions for the BSCB Business Plan 2017-18.

This year we have incorporated the views of children and young people in BSCB audit activity. A consistent message in all our audits has been that the experience of children and young people is insufficiently heard. In 2017/18 we will be working with the Children's Trust and partners to deliver training for practitioners across the children's workforce in this area. Young people will be involved in the delivery of that training. The Voice of the Child continues to be an agenda item at BSCB meetings.



15. Conclusion

The data presented above evidences the progress that has been made with the challenges set in 2016/17 for the BSCB. The BSCB continues to be ambitious and sets high expectations of its partners. This has been met with good support and contribution.

The BSCB continues to be ambitious in expectations of its partners. This has been met with good support and contribution.

Overall, looking back over 2016/17 the BSCB through all its partners delivered a strong, effective and challenging programme of work designed to consistently and continuously improve what it is like to be a child growing up in Bury.

Whilst there is, as always, a lot to still to do perhaps the greatest challenge for the next twelve months is maintaining progress in a challenging public sector environment, through a time of policy changes and new national priorities without losing sight of what matters – the safety and welfare of the children and young people of Bury.

16. Challenges the BSCB has set for itself for 2017/18

The BSCB has identified the four priority areas for action for the forthcoming year (2017/18). This year the BSCB will focus on monitoring and responding to:

1. Children and young people impacted by domestic violence

We have already begun to work with our partners in the Community Safety Partnership to improve practice and outcomes for this vulnerable group of children. We have been working with our partners to scrutinise the Bury Domestic Abuse strategy and we will receive regular reports of progress and impact over the next twelve months.

2. Complex safeguarding issues, including CSE, FGM & radicalisation

We have already begun to work with our partners regionally and to hold them to account for the strategic work being undertaken across Greater Manchester to address these complex areas of safeguarding practice. We have sought data and reassurance regarding the local picture for Bury children and we have held a series of awareness raising events and training activities to improve recognition and response from professionals.

3. Safeguarding in the context of technology and social media

The online world is now an integral part of everyday life for young people. The internet brings great opportunity to communicate and learn. Unfortunately there are individuals who misuse the internet to make inappropriate contact with young people for the purposes of scams, bullying, sexual grooming or abuse. Throughout 2017/18 we will be seeking assurance from our partners that e-safety is integral to the work that they do and that members are appraised of the work being done locally to keep them safe.

4. Mental/health/emotional well-being needs

We will be working with our partners in the Children's Trust to co-deliver training activities to ensure that the children and young people's workforce will understand the signs and symptoms of mental health or emotional wellbeing issues, what to do and when/where to refer.

Success and impact will be will be measured by the Children's Trust and reported to the BSCB via scrutiny of the local Transformation Plan.

Appendix 1

Projected Income & Expenditure
2017-18

Contributions/Income	**£**
Children's Services	72,181.00
Prior Year Underspend Brought Forward	23,800.00
Bury CCG	37,142.00
Greater Manchester Police	11,850.00
CAFCASS	550.00
National Probation Service	896.00
Community Rehabilitation Company	2,081.00
Training Income	7,500.00
DSG Contribution	40,000.00
TOTAL INCOME	**196,000.00**

Expenditure	£
Employee Costs	154,300.00
Multi-Agency Training Costs	14,100.00
Serious/Critical Case Reviews	6,000.00
Indpendent Chair of BSCB	12,000.00
Travel & Substance	1,200.00
Advertising - Staff	0.00
Postage	400.00
Telephone	1,000.00
Office Overheads incl Equipment, Tools & Materials	8,400.00
Printing & Stationary	1,500.00
Central Recharges (Admin Buildings etc)	13,000.00
Staff Training	0.00
Contribution to CDOP Centralised Budget (Oldham MBC)	10,600.00
Miscellaneous	0.00
Employers Liability & 3rd Party Insurance	600.00
TOTAL EXPENDITURE	**223,100.00**

Total Net Budget 2016/17			**27,100.00**

Appendix 2

Team Oasis April 2017.docx

Appendix 3

CSE Annual Report 2016 - 2017.docx

Appendix 4

Private Fostering BSCB Annual Report 1